STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	05/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00089515. Complaint IN00089515-Substantiated, Federal/State deficiencies are cited at F 242, F282, and F312. Survey dates: May 9 and 10, 2011 Facility number: 000517 Provider number: 155714 AIM number: 100266770 Survey team: Anne Marie Crays, RN Census bed type: SNF/NF: 28 Total: 28 Census payor type: Medicare: 1 Medicaid: 21 Other: 6	F0000	F000 By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective June 9, 2011 to the state findings of the annual survey conducted on May 10th, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 28 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 12, 2011 by Bev Faulkner, RN			

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F0242 SS=E	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview, and record review, the facility failed to ensure residents were dressed and out of bed at a reasonable time, and instead got residents up and/or dressed before 5:00 A.M., for 4 of 5 residents reviewed for morning care, in a sample of 5. Residents A, B, C, and D Findings include: 1. On 5/9/11 at 4:55 A.M., CNA # 1 indicated night shift staff "have a get-up list that tells them when to get residents up." CNA # 1 indicated staff "started at 4:00 A.M." On 5/9/11 at 5:10 A.M., LPN # 1 provided a "Resident Shower Schedule," dated May 3, 2011. The	F0242	F242 The corrective action taken for those residents found to be affected by the deficient practice is that Oak Village, Inc. has written a new policy prohibiting the use of a “get up list” and that this list is no longer in use. Residents identified as A,B,C, and D have been reassessed as to their preference of time to rise in the mornings. Residents A, B, and C are unable to communicate a time they prefer to rise in the morning at the time of assessment. However, they are able to communicate when they are ready to get up on random days by opening eyes, attempting to rise, etc. If no preference is stated or indicated no resident will rise before 5 a.m. Resident D is totally dependent with a diagnosis of Alzheimers and is unable to communicate wants or needs with the exception of facial grimacing when in pain. Therefore, this resident will not be up in the mornings before 6:00 am. Residents A, B, C, and D careplans were updated to reflect these findings. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the	06/09/2011

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	schedule included: "Night Shift... Get Ready List:...Resident D, Get Up List:...Resident C, Resident A, Resident B. And any others would be greatly appreciated, especially when dayshift is short staffed and especially on Mondays and Thursdays...please get more residents ready and/or up...." During interview, on 5/9/11 at 5:10 A.M., LPN # 1 indicated night shift staff work from 10:00 P.M. until 6:00 A.M. 2. On 5/9/11 at 4:40 A.M., upon entrance to the facility, Resident D was observed sitting in a reclining Broda chair by the nurses' station, groomed and dressed in street clothes. The resident's eyes were closed. LPN # 1 indicated at that time that there was "a small group of residents that get their showers and get dressed between 4:00 A.M. and 5:00 A.M." LPN # 1 indicated that Resident D required total care from staff.		potential to be affected by this deficient practice. A house-wide assessment was completed to determine preference of rising times in the mornings. Based on the outcome of the assessments residents will rise at their preference whether by statement or action. If no statement or action available no resident will rise before 5 a.m. Totally dependent residents who are unable to communicate their wishes will not rise until 6:00 a.m. A house-wide careplan audit will be conducted with the careplans updated according to the outcome of the assessments. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory inservice was conducted for all licensed or certified nursing staff on the resident's right to make choices, including the right to rise in the mornings at their preference either by statement or action. If no statement or action available no resident will rise before 5 a.m and totally dependent residents who are unable to make needs known by statement or action will not rise before 6:00 a.m. The inservice included how to determine if a resident, who is confused or unable to verbally communicate, wishes to rise before 5 a.m. The requirement of following the plan of care was addressed as well.	

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	The clinical record of Resident D was reviewed on 5/9/11 at 8:10 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia. An Initial Activity Assessment, dated 3/5/08, indicated, "...What time do you like to get up in the morning? [Left blank]...." The most recent Minimum Data Set [MDS] assessment, dated 5/4/11, indicated Resident D was unable to respond to a memory test, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two+ persons for transfer, dressing, and personal hygiene. Documentation or a care plan was lacking regarding the resident wishing to get up before 5:00 A.M. On 5/9/11 at 7:00 A.M., Resident D was observed sitting in a Broda chair by the nurses station, eyes		The corrective action taken to monitor the corrective action is a Quality Assurance tool was developed and implemented to monitor the rising time of all residents. This tool includes the residents preference if available. Residents stating a preference will be given that choice and will rise at the preferred time unless otherwise indicated by the resident. Careplans will be updated on an ongoing basis. This tool will be completed daily by the Night Shift Charge Nurse and reviewed by the Director of Nursing or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the monthly Quality Assurance meeting to determine if any additional interventions are warranted. Completion Date June 9th, 2011	

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	closed. On 5/9/11 at 7:30 A.M., Resident D was observed sitting in the dining room, with her eyes closed. 3. On 5/9/11 at 4:40 A.M., Resident C was observed sitting in a wheelchair by the nurses' station, groomed and fully dressed. Resident C's eyes were open. The clinical record of Resident C was reviewed on 5/9/11 at 5:35 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia. An Initial Activity Assessment, dated 5/9/08, indicated, "...What time do you like to get up in the morning? 6 AM...." The most recent Minimum Data Set [MDS] assessment, dated 5/3/11, indicated the resident had memory problems, and required extensive assistance of two+ staff for transfer. The MDS assessment indicated			

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	Resident C required total dependence on 1 person for dressing, and extensive assistance of two+ staff for personal hygiene. Documentation or a care plan was lacking regarding the resident wishing to get up prior to 5:00 A.M. On 5/9/11 at 7:00 A.M., Resident C was observed sitting in her wheelchair by the nurses' station, eyes closed. On 5/9/11 at 7:30 A.M., Resident C was observed sitting in the dining room, with her eyes closed. 4. On 5/9/11 at 4:55 A.M., CNA # 1 was observed ambulating with Resident A to the nurses' station. Resident A was groomed and dressed. The clinical record of Resident A was reviewed on 5/9/11 at 7:45 A.M. Diagnoses included, but were not limited to, Advanced Dementia.			

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An Initial Activity Assessment, dated 12/22/09, indicated, "...What time do you like to get up in the morning? 7:30 or 8:00 AM...."

A Minimum Data Set [MDS] assessment, dated 4/19/11, indicated Resident A had a short-term and long-term memory problem, required limited assistance of one person for transfer, and extensive assistance of one person for dressing and personal hygiene.

Documentation or a care plan was lacking regarding the resident wishing to get up prior to 5:00 A.M.

On 5/9/11 at 7:00 A.M., Resident A was observed sitting in a chair by the nurses station, with her eyes closed.

On 5/9/11 at 7:30 A.M., Resident A was observed sitting at the dining room table, with her eyes closed.

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5. On 5/9/11 at 4:40 A.M., Resident B was observed to be lying in bed, dressed in a street shirt, with a sheet over her.

The clinical record of Resident B was reviewed on 5/9/11 at 6:30 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease.

An Initial Activity Assessment, dated 7/7/09, indicated, "...What time do you like to get up in the morning? [Left blank]...."

A Minimum Data Set [MDS] assessment, dated 3/7/11, indicated Resident B had memory problems, and required extensive assistance of one person for transfer, dressing, and personal hygiene.

Documentation or a care plan was lacking regarding the resident's wishes to get dressed in the morning prior to 5:00 A.M.

On 5/9/11 at 5:25 A.M., Resident B

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	was observed sitting in a wheelchair by the nurses station, groomed and dressed. 6. During interview with the Administrator on 5/10/11 at 11:40 A.M., she indicated she had no idea the night shift was getting people up "that early," and would not expect to have residents be up and dressed prior to 5:00 A.M. unless they requested it. This federal tag relates to Complaint IN00089515 3.1-3(u)(1)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure care plan interventions were followed, in that residents dependent for care were not turned and repositioned at least every two hours, and toileted at least every 2 hours, for 2 of 4 residents reviewed for care plans, in a sample of 5. Resident D, Resident C Findings include: 1. On 5/9/11 at 4:40 A.M., upon entrance to the facility, Resident D was observed sitting in a reclining Broda chair by the nurses station,	F0282	F282 The corrective action taken for those residents found to be affected by the deficient practice is that a careplan review was conducted for residents D and C specifically addressing their dependence for turn/repositioning and toileting. The careplans were updated accordingly. An inservice was given to each shift licensed and certified nursing staff as to the need for following the resident's careplan and specifically the turning/repositioning and toileting of residents identified as D and C. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. A housewide audit of resident careplans was conducted specifically addressing level of dependence for turning/repositioning and toileting of all residents.	06/02/2011

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	groomed and dressed in street clothes. The resident's eyes were closed. LPN # 1 indicated at that time that there was "a small group of residents that get their showers and get dressed between 4:00 A.M. and 5:00 A.M." LPN # 1 indicated that Resident D required total care from staff. Resident D was observed to remain in the reclining Broda chair at the nurses station until 7:30 A.M., when the resident was moved to the dining room where the resident remained. At 8:55 A.M., the resident was transferred to bed by CNA # 2 and # 3. The resident was observed in the chair from 4:40 A.M. until 8:55 A.M. without a position change or incontinence check. The clinical record of Resident D was reviewed on 5/9/11 at 8:10 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia.		Careplans were updated accordingly. A list of residents has been placed in a binder at the nurse's station with their specific turn/reposition and toileting careplan. CNA assignment sheets were also updated to reflect any changes. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory inservice has been conducted for all licensed and certified nursing staff on the requirement to follow a resident's careplan at all times and specifically the turning/toileting and repositioning of a dependent resident. This inservice included a review of the issues of skin breakdown. The corrective action taken to monitor the corrective action is a Quality Assurance tool was developed and implemented to monitor the turning/toileting and repositioning of dependent residents. This tool will be completed by the Charge Nurse on duty each shift daily and reviewed by the Director of Nursing weekly for four weeks, monthly for three months, quarterly for three quarters. This tool will also be used for random checks one time weekly by Director of Nursing. The outcome of this tool will be reviewed at the monthly QA to see if further action is warranted.	

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	The most recent Minimum Data Set [MDS] assessment, dated 5/4/11, indicated Resident D was unable to respond to a memory test, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two+ persons for transfer, dressing, and personal hygiene. A Resident Care Plan, initial date 3/6/08 and updated on 2/11, indicated a problem of "At risk for skin breakdown R/T [related to] [decreased] mobility et [and] incont [incontinent] of [bowels and bladder]." The approaches included: "1. Change positions freq when up in recliner...3. Check freq keep clean et dry...." On 5/10/11 at 11:40 A.M., the Administrator indicated she would have expected her staff to reposition and toilet the resident at least every 2 hours. 2. On 5/9/11 at 4:40 A.M., Resident		Completion Date 6-9-11	

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	C was observed sitting in a wheelchair by the nurses station, groomed and fully dressed. Resident C's eyes were open. Resident C was observed to remain in the wheelchair by the nurses' station until 7:30 A.M., when the resident was then moved to the dining room where the resident remained. At 8:40 A.M., the resident was transferred to the commode by CNA # 2 and # 3. The resident was observed in the chair from 4:40 A.M. until 8:40 A.M. without a position change or incontinence check. The clinical record of Resident C was reviewed on 5/9/11 at 5:35 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia. A Resident Care Plan, initially dated 10/10 and updated 2/11, indicated a problem of "Increase incont. of bowels et bladder." The approaches indicated, "Toilet q			

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	[every] 2h [hours] et PRN [as needed]...." The most recent Minimum Data Set [MDS] assessment, dated 5/3/11, indicated the resident had memory problems, and required extensive assistance of two+ staff for transfer. The MDS assessment indicated Resident C required total dependence on 1 person for dressing and toilet use, and extensive assistance of two+ staff for personal hygiene. The MDS assessment indicated Resident C was always incontinent of bladder, and frequently incontinent of bowels. On 5/10/11 at 11:40 A.M., during interview with the Administrator, she indicated she would have expected her staff to toilet the resident at least every 2 hours. This federal tag relates to Complaint IN00089515 3.1-35(g)(2)			

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F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents dependent for care were turned and repositioned at least every two hours, and toileted at least every 2 hours, for 2 of 4 residents reviewed for care plans, in a sample of 5. Resident D, Resident C Findings include: 1. On 5/9/11 at 4:40 A.M., upon entrance to the facility, Resident D was observed sitting in a reclining Broda chair by the nurses station, groomed and dressed in street	F0312	F312 The corrective action taken for those residents found to be affected by the deficient practice is that residents identified as C and D careplans were reviewed. An inservice was conducted on all licensed and certified nursing staff to specifically address that residents C and D are to be given care according to their careplan. Specifically they are to be turned/repositioned and toileted every two hours and prn regardless of what time they rise in the mornings. Residents C and D are to receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the	06/09/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clothes. The resident's eyes were closed. LPN # 1 indicated at that time that there was "a small group of residents that get their showers and get dressed between 4:00 A.M. and 5:00 A.M." LPN # 1 indicated that Resident D required total care from staff. The clinical record of Resident D was reviewed on 5/9/11 at 8:10 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia. The most recent Minimum Data Set [MDS] assessment, dated 5/4/11, indicated Resident D was unable to respond to a memory test, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two+ persons for transfer, dressing, and personal hygiene. A Resident Care Plan, initial date 3/6/08 and updated on 2/11, indicated a problem of "At risk for		potential to be affected by the deficient practice. A house-wide review of all residents careplans has been conducted. Based on the outcome of the review it was determined which residents are unable to carry out activities of daily living. All residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene in accordance to their individual careplan. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory inservice was conducted for all licensed and certified nursing staff on the policy of providing necessary services to maintain good nutrition, grooming, and personal and oral hygiene for any resident who is unable to carry out activities of daily living. Completion of careplans, updating of careplans, and following the resident's plan of care were also addressed. The corrective action taken to monitor to assure performance and compliance is that a Quality Assurance tool was developed and implemented to monitor the turning/repositioning and toileting of dependent residents. This tool will be completed by Charge Nurse each shift. The Director of Nursing will	

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	155714	A. BUILDING 00 B. WING	05/10/2011

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	skin breakdown R/T [related to] [decreased] mobility et [and] incont [incontinent] of [bowels and bladder]." The approaches included: "1. Change positions freq when up in recliner...3. Check freq keep clean et dry...." On 5/9/11, Resident D was observed sitting in a reclining Broda chair at the nurses station at 4:40 A.M., 5:25 A.M., and 7:00 A.M. Resident D was observed sitting in a Broda chair at the dining room table at 7:30 A.M. and 8:00 A.M. At 8:00 A.M., CNA # 2 and CNA # 3 were interviewed regarding if they lay Resident D down after breakfast, and both responded that they did. A skin assessment was requested on Resident C when they were able to lay her down. On 5/9/11 at 8:55 A.M., CNA # 3 indicated they were going to transfer Resident D to bed. CNA # 2 and CNA # 3 transferred the resident to bed with a mechanical		monitor this tool daily and perform random checks throughout each shift weekly for four weeks, monthly for three months and quarterly for for three quarters. The outcome will be reviewed at the monthy Quality Assurance meeting to determine if any additional interventions are warranted. completion date 6-10-11	

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	lift. The resident's brief was wet with urine. The resident's buttocks were slightly reddened and had indentations from the brief. On 5/10/11 at 11:40 A.M., during interview with the Administrator, she indicated she would have expected her staff to reposition the resident at least every 2 hours. 2. On 5/9/11 at 4:40 A.M., Resident C was observed sitting in a wheelchair by the nurses station, groomed and fully dressed. Resident C's eyes were open. The clinical record of Resident C was reviewed on 5/9/11 at 5:35 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia. A Resident Care Plan, initially dated 10/10 and updated 2/11, indicated a problem of "Increase incont. of bowels et bladder." The approaches indicated, "Toilet q [every] 2h [hours] et PRN [as			

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	needed]...." The most recent Minimum Data Set [MDS] assessment, dated 5/3/11, indicated the resident had memory problems, and required extensive assistance of two+ staff for transfer. The MDS assessment indicated Resident C required total dependence on 1 person for dressing and toilet use, and extensive assistance of two+ staff for personal hygiene. The MDS assessment indicated Resident C was always incontinent of bladder, and frequently incontinent of bowels. On 5/9/11 Resident C was observed to be sitting at the nursing station in a wheelchair at 4:40 A.M., 5:25 A.M., and 7:00 A.M. At 7:30 A.M. and 8:00 A.M., Resident C was observed sitting in a wheelchair at the dining room table. At 8:00 A.M., a skin assessment was requested on Resident C when she was taken to the bathroom or laid down.			

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	On 5/9/11 at 8:40 A.M., CNA # 2 and CNA # 3 indicated they were going to take Resident C to the bathroom. CNA # 3 indicated Resident C was usually incontinent, but that she "sometimes tells us when she has to go." The resident's brief was observed to be wet with urine, and the resident also voided into the commode. A raised, rash-like area was observed over the resident's buttocks. On 5/10/11 at 11:40 A.M., during interview with the Administrator, she indicated she would have expected her staff to toilet the resident at least every 2 hours. This federal tag relates to Complaint IN00089515 3.1-38(a)			

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